SASKATOON HEALTH REGION
Saskatoon, Saskatchewan

❑ RUH ❑ SCH ❑ SPH Other _________

Patient Label

NAME: ______________________________

HSN: ________________________________

D.O.B.: ______________________________

REFUSAL OF CONSENT FOR THE ADMINISTRATION OF BLOOD COMPONENTS AND/OR PLASMA PROTEIN PRODUCTS

I, ____, hereby
(Please print first and last name)

Refuse the administration of blood components and/or plasma protein products. I understand such treatment may be deemed necessary in the opinion of the physician or medical staff of this health region to preserve my life or promote my recovery. I have been given the opportunity to ask questions regarding the benefits and risks of administration of blood components and/or plasma protein products made from blood.

I hereby release the Saskatoon Regional Health Authority and its medical staff connected with my treatment from any responsibility for any results due to my refusal to permit the administration of blood components and/or plasma protein products.

I acknowledge the risks and consequences which may arise as a result of my refusal to permit the administration of blood components and/or plasma protein products made from blood. These risks and benefits have been adequately explained to me. The possible uses of alternative treatments have also been discussed and I understand the benefits and risks of these alternative treatments.

According to my decision, **I WILL ACCEPT ONLY** the following products:

I certify I have read/have had read to me/have had interpreted to me, and understand and agree to the above statements. I acknowledge I have the right to change my mind at any time.

______________________________	______________________________
Signature (Patient or person providing consent)	*Date and Time of Consent*
______________________________	______________________________
Print Name of Witness	*Signature (Witness)*
______________________________	______________________________
Print Name of Interpreter	*Signature of Interpreter (where applicable)*
______________________________	______________________________
Print Name of MRHP	*Signature (MRHP)*